Supreme Court, U.S.
FILED
06-839 DEC 14 2006
OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R. FOTI, JR., Attorney General for the State of Louisiana; DAUTERIVE HOSPITAL,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

HOWARD SHAPIRO
Counsel of Record
HEATHER G. MAGIER
PROSKAUER ROSE LLP
909 Poydras Street, Suite 1100
New Orleans, LA 70112
(504) 310-4088
Attorneys for Petitioner

QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* ("ERISA"), preempts a state law that purports to override lawful ERISA plan terms that prohibit the assignment of benefit claims, because the state law relates to ERISA plans within the meaning of ERISA Section 514(a), 29 U.S.C. § 1144.

2. Whether ERISA preempts a state law that authorizes an action to collect benefits previously paid to a plan participant and establishes a remedy outside ERISA's exclusive civil enforcement scheme, because the state law conflicts with the cause of action for benefits set forth in ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

LIST OF PARTIES TO THE PROCEEDING

The names of all parties to the proceeding in the United States Court of Appeals for the Fifth Circuit appear in the caption of the case on the cover page.

CORPORATE DISCLOSURE STATEMENT PURSUANT TO RULE 29.6

Pursuant to Supreme Court Rule 29.6, Petitioner states that it has no parent companies or non-wholly owned subsidiaries, and no publicly held company owns ten percent or more of Petitioner's stock.

TABLE OF CONTENTS

QUESTIONS PRESENTED i

LIST OF PARTIES TO THE PROCEEDING ii

CORPORATE DISCLOSURE STATEMENT PURSUANT TO RULE 29.6 ii

TABLE OF CONTENTS iii

INDEX TO APPENDICES v

TABLE OF AUTHORITIES vi

PETITION FOR A WRIT OF CERTIORARI 1

OPINIONS BELOW 1

JURISDICTION 1

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 2

STATEMENT OF THE CASE 2

I. INTRODUCTORY STATEMENT 2

II. FACTUAL BACKGROUND 4

III. HISTORY OF PROCEEDINGS 5

REASONS FOR GRANTING THE PETITION 8

I. INTRODUCTORY STATEMENT 8

II. ARGUMENT 13

A. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that relate to ERISA plan administration 13

B. The Court should grant review because the Fifth Circuit decision conflicts directly with decisions of other circuits 17

C. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that conflict with ERISA's exclusive enforcement mechanism 20

D. This Court's review is warranted to resolve recurring questions of considerable significance to preemption jurisprudence, and of practical importance to the health care community 25

CONCLUSION 28

APPENDICES ..... 1a - 65a

INDEX TO APPENDICES

A. DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, AUGUST 16, 2006 ..... 1a

B. DECISION OF THE UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF LOUISIANA, OCTOBER 12, 2004 ..... 33a

C. DECISION OF THE UNITED STATES DISTRICT COURT, MIDDLE DISTRICT OF LOUISIANA, APRIL 15, 2002 ..... 39a

D. ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT DENYING PETITION FOR REHEARING *EN BANC*, SEPTEMBER 15, 2006 ..... 53a

E. JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, ISSUED AS MANDATE, SEPTEMBER 25, 2006 ..... 55a

F. UNITED STATES. CONSTITUTION, ARTICLE VI, CLAUSE 2 ..... 57a

G. ERISA PROVISIONS 58a

H. *LA. REV. STAT. ANN §* 40 :2010 ..... 63a

I. BLUE CROSS SAMPLE PLAN EXCERPT: DIRECT PAYMENT PROVISION 64a

TABLE OF AUTHORITIES

CASES

Aetna Health Inc. v. Davila,
542 U.S. 200 (2004) ..... *passim*

Alessi v. Raybestos-Manhattan, Inc.,
451 U.S. 504 (1981) ..... *passim*

Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.,
947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992) 17, 19

Boggs v. Boggs,
520 U.S. 833 (1997) 11, 24

Braxton v. United States,
500 U.S. 344 (1991) 17

CIGNA Healthplan v. Louisiana ex rel. Ieyoub,
82 F.3d 642 (5th Cir.), cert. denied, 519 U.S. 964 (1996) 6

California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.,
519 U.S. 316 (1997) ..... *passim*

City of Hope Nat'l Med. Center v. Healthplus, Inc.,
156 F.3d 223 (1st Cir. 1998) 18

Clancy v. Employers Health Ins. Co.,
101 F. Supp. 2d 463 (E.D. La. 2000) 22

Cobb v. Cent. States,
461 F.3d 632 (5th Cir. 2006) 15

Curtiss-Wright Corp. v. Schoonejongen,
514 U.S. 73 (1995) 12, 19

Davidowitz v. Delta Dental Plan, Inc.,
946 F.2d 1476 (9th Cir. 1991) 19

DeBartolo v. Blue Cross Blue Shield of Illinois, No.
01 C 5940, 2001 WL 1403012 (N.D. Ill. Nov. 9,
2001) 18

De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,
520 U.S. 806 (1997) 11, 26

District of Columbia v. Greater Washington Bd. of Trade,
506 U.S. 125 (1992) 11

Egelhoff v. Egelhoff,
532 U.S. 141 (2001) ..... *passim*

FMC Corporation v. Holliday,
498 U.S. 52 (1990) 11, 12

Fort Halifax Packing Co. v. Coyne,
482 U.S. 1 (1987) 11

Ingersoll-Rand Co. v. McClendon,
498 U.S. 133 (1990) 11, 20

John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank,
510 U.S. 86 (1993) 11

Ky. Ass'n of Health Plans, Inc. v. Miller,
538 U.S. 329 (2003) 11

La. Health Serv. & Indemnity Co. v. Rapides Healthcare System,
213 F. Supp. 2d 650 (M.D. La. 2002) 1

La. Health Serv. & Indemnity Co. v. Rapides Healthcare System,
461 F.3d 529 (5th Cir. 2006) ..... *passim*

LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.,
298 F.3d 348 (5th Cir. 2002) 18

Lockheed Corp. v. Spink,
517 U.S. 882 (1996) 25

Mackey v. Lanier Collection Agency & Serv.,
486 U.S. 825 (1988) 11

Mass. Mut. Life Ins. Co. v. Russell,
473 U.S. 134 (1985) 24

Massachusetts v. Morash,
490 U.S. 107 (1989) 11

Mertens v. Hewitt Associates,
508 U.S. 248 (1993) 25

Metropolitan Life Ins. Co. v. Massachusetts,
471 U.S. 724 (1985) 11, 12

Metropolitan Life Ins. Co. v. Taylor,
481 U.S. 58 (1987) 10, 11

New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.,
514 U.S. 645 (1995) ..... *passim*

Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.,
371 F.3d 1291 (11th Cir.), *cert. denied*, 543 U.S. 1002 (2004) 18

Pilot Life Ins. Co. v. Dedeaux,
481 U.S. 41 (1987) 11, 20

Rush Prudential HMO, Inc. v. Moran,
536 U.S. 355 (2002) ..... *passim*

Shaw v. Delta Air Lines, Inc.,
463 U.S. 85 (1983) ..... *passim*

St. Francis Regional Medical Ctr. v. Blue Cross & Blue Shield,
49 F.3d 1460 (10th Cir. 1995) 17, 19

Surgicore, Inc. v. Principal Life Ins. Co., No. 01
2001 WL 1403012 (N.D. Ill. Nov. 9, 2001); 18

UNUM Life Ins. Co. of Am. v. Ward,
526 U.S. 358 (1999) 10, 19

Varity Corp. v. Howe,
516 U.S. 489 (1996) 13

CONSTITUTIONAL AND STATUTORY PROVISIONS

U.S. Const., art. VI, cl.2 2

28 U.S.C. § 1254(1) 2

28 U.S.C. § 1291 1

28 U.S.C. § 1331 ..... 1, 5

28 U.S.C. § 2201 5

29 U.S.C. §§ 1001, *et seq.* (ERISA) 1, 2

29 U.S.C. § 1002(8), Section 3(8) of ERISA..... 14, 15, 16

29 U.S.C. § 1102(a)(1), Section 402(a)(1) of ERISA 13

29 U.S.C. § 1102(b)(4), Section 402(b)(4) of ERISA 11, 14, 16

29 U.S.C. § 1104(a)(1), Section 404(a)(1) of ERISA..... 23

29 U.S.C. §§1104(a)(1)(D), Section 404(a)(1)(D) of ERISA 14

29 U.S.C. § 1132(a), Section 502(a) of ERISA 10, 25

29 U.S.C. § 1132(a)(1), Section 502(a)(1)(B) of ERISA 1, 14, 23

29 U.S.C. § 1132(e), Section 502(e) of ERISA 1, 5

29 U.S.C. § 1144, Section 514 of ERISA ..... *passim*

29 U.S.C. § 1144(a), Section 514(a) of ERISA ..... *passim*

S. Ct. R. 10(a) 17

Fed.R.Civ.P. 57 5

La. Rev. Stat. Ann. § 40:2010 (2001) ..... *passim*

LEGISLATIVE HISTORY

120 Cong. Rec. 29197 (1974) 9

120 Cong. Rec. 29933 (1974) 9

In the
Supreme Court of the United States

PETITION FOR A WRIT OF CERTIORARI

Petitioner Louisiana Health Service & Indemnity Co. (d/b/a Blue Cross and Blue Shield of Louisiana) ("Blue Cross") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 461 F.3d 529 (5th Cir. 2006) (App. A). The October 12, 2004, opinion and order of the United States District Court for the Middle District of Louisiana is unreported (App. B). The April 15, 2002, opinion and order of the United States District Court for the Middle District of Louisiana is reported at 213 F. Supp. 2d 650 (M.D. La. 2002) (App. C).

JURISDICTION

The district court had federal question jurisdiction over Blue Cross's claim pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e), insofar as an action asserted against a State, seeking a declaratory judgment of preemption, presents a federal question arising under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001, *et seq.* ("ERISA"). The court of appeals had jurisdiction to review the final judgment of the district court pursuant to 28 U.S.C. § 1291. The date on which the United States Court of Appeals for the Fifth Circuit decided this case was August 16, 2006. A timely petition for rehearing *en banc* was

denied by the Fifth Circuit on September 15, 2006 (App. D). Judgment was issued as mandate on September 25, 2006 (App. E). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. Const., art. VI, cl.2, the pertinent provisions of ERISA, 29 U.S.C. §§ 1001, *et seq.*, and the Louisiana statute at issue, *La. Rev. Stat. Ann.* § 40:2010 (2001), are set forth in the Appendices, App. F, G, and H, respectively.

STATEMENT OF THE CASE

I. INTRODUCTORY STATEMENT

The Fifth Circuit's ruling that ERISA does not preempt a state assignment statute has created a split among the circuits and a conflict with decisions of this Court regarding the breadth of ERISA preemption – a recurring and contentious issue of great significance to employers, employees, health plans, and plan participants. Despite clearly expressed congressional intent that ERISA preempt the field of employee benefit plan regulation and enforcement,[1] the panel decision allows a State to mandate the inclusion in ERISA plans of particular contractual terms governing plan administration, and to establish a cause of action and remedy for ERISA benefit claims in addition to a payment to the plan participant.

---

[1] *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 336 (1997) (Scalia, J., concurring; Ginsburg, J., joining).

Even in decisions that ostensibly curtailed the reach of ERISA preemption, this Court reaffirmed that ERISA preempts any state law that purports to regulate the plan itself or conflicts with ERISA directly. Thus, ERISA necessarily preempts state laws that "mandate employee benefit structures or their administration," or provide "alternative enforcement mechanisms." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

By prohibiting the inclusion of a lawful plan term barring assignment, *La. Rev. Stat. Ann.* § 40:2010 ("the Assignment Statute") mandates a particular benefit payment structure, and thus relates to ERISA. *See Egelhoff v. Egelhoff,* 532 U.S. 141, 148 (2001) (ERISA preempts state statute that requires administrators to pay benefits to beneficiaries chosen by state law, rather than to those identified in plan documents, because it runs counter to ERISA's command that fiduciaries administer plan in accordance with governing documents, and governs benefit payments, a central matter of plan administration). By establishing a state cause of action that potentially results in a double payment of benefits or a penalty, the Assignment Statute provides a conflicting, alternative enforcement mechanism. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (ERISA preempts state law that conflicts with ERISA's exclusive enforcement scheme by supplementing or supplanting ERISA claims or remedies). In a decision that arguably applies to all ERISA-governed plans, both insured and self-funded,[2] the Fifth Circuit here reached a result that is contrary to these ostensibly straightforward principles and conflicts with decisions of the Eighth and Tenth Circuits. Review by this Court will provide much

---

[2] *See infra,* footnote 12.

needed clarity and guidance in an area of continued confusion in the lower courts.

II. FACTUAL BACKGROUND

Blue Cross underwrites, provides, or administers various forms of health benefits through individual, association, and employer health benefits plans. The most common form of group health plan offered is a "participating provider" plan that extends higher levels of benefits when members choose to obtain services from providers who are part of a designated network of providers. These participating provider plans benefit plan sponsors and participants by keeping premiums and out-of-pocket costs lower, and benefit providers by supplying a large pool of potential patients.

Contracts for group health insurance policies issued or administered by Blue Cross, including ERISA plans, provide that all benefits payable are personal to the plan member and are not assignable in whole or in part. (App. I). However, the plans may pay benefits directly to "participating providers" who have executed contracts for direct payment. Thus, these direct payment provisions permit the plans to pay benefits directly only to members or to participating providers. These are lawful ERISA plan terms, and ERISA obligates Blue Cross to pay benefits in accordance with those terms.

The Assignment Statute requires an entity that is obligated to pay medical benefits for hospital services to recognize any assignment to the hospital of an individual's right to those benefits. In pertinent part, the statute provides that if the payor-entity has notice of an assignment, payment to the individual plan participant will neither release that

entity from liability to the hospital, nor provide a defense to an action by the hospital to collect such benefits. (App. I).

Thus, if an ERISA plan acts in accordance with the Blue Cross direct payment provision and pays benefits directly to the individual plan participant, the Assignment Statute nevertheless requires the ERISA plan to pay the hospital – in effect requiring a double payment on a single liability. In the alternative, the Assignment Statute requires the ERISA plan to disregard the lawful ERISA plan provisions entirely, and pay benefits to the hospital, in violation of the controlling ERISA plan terms.

III. HISTORY OF PROCEEDINGS

Rapides Healthcare System submitted complaints to the Louisiana Department of Insurance ("DOI") alleging that various actions by Blue Cross violated state statutory provisions, including the Assignment Statute. In January 2001, the DOI Office of Health Insurance issued its determination, *inter alia,* that Blue Cross health insurance policies violate Louisiana law to the extent they prohibit members from assigning their benefits to hospitals.

Following the DOI determinations, Blue Cross filed a complaint pursuant to *Fed.R.Civ.P.* 57 and 28 U.S.C. §2201, seeking a declaratory judgment that ERISA preempts the provisions of *La. Rev. Stat. Ann.* § 40:2010 as applied to fully insured employee benefit plans governed by ERISA and insured or administered by Blue Cross, and that the DOI, the Attorney General, Rapides, or any other private party, is precluded from pursuing any action against Blue Cross to ensure compliance with its provisions. The District Court had subject matter jurisdiction pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1132(e), insofar as an action asserted against

the State, seeking a declaratory judgment of preemption, presents a federal question arising under ERISA.[3]

On April 15, 2002, the District Court issued its Ruling denying Blue Cross's motion for summary judgment. The District Court determined that ERISA does not preempt the Assignment Statute because the statute is a "general health care regulation" not intended by Congress to be preempted, an assignment of benefits facilitates the employee's receipt of benefits, and the statute had at most only an indirect economic effect on ERISA plans. Further, the court held that ERISA's silence on the issue of assignability of welfare benefits "indicates that Congress intended to allow the states to make their own decisions regarding assignability." Ruling p.12 (App. C). In October 2004, the District Court reaffirmed its prior ruling. (App. B).

On August 16, 2006, the Fifth Circuit affirmed the District Court's decision. The panel concluded that the Assignment Statute is not "conflict preempted" as a law that conflicts with ERISA's exclusive enforcement mechanism because it does not impose any obligation on the ERISA plan administrator, nor create a separate or additional means of enforcement; the statute "merely passes the sole enforcement mechanism--ERISA § 502--from patient to hospital ...." 461 F.3d 529 at 535 (App. at 10a). The panel rejected Blue Cross's argument that the statute conflicts with ERISA by sanctioning a state law action "to collect benefits," and by establishing a remedy outside of ERISA by requiring a benefits payment to the hospital even if the plan has already paid benefits to the participant. The panel reasoned that if

---

[3] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983); *CIGNA Healthplan v. Louisiana ex rel. Ieyoub*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996).

Blue Cross complies with the Assignment Statute, it only pays the benefit once, and any "mistaken" payment to the participant could be remedied by seeking recovery of that payment from the person improperly paid. *Id.*, at 536 (App. at 11a).

The panel further determined that the statute is not expressly preempted under ERISA § 514 as a state law that "relates to" ERISA based on its reference to or connection with an ERISA plan.[4] The panel determined that the law does not "refer" to an ERISA plan because it applies neutrally to ERISA plans and other types of plans. *Id.,* at 536 (App. at 13a). The panel further determined that the Assignment Statute does not have an impermissible "connection with" ERISA plans, because by requiring a plan to recognize an assignment, the statute is merely enforcing the participant's choice to designate a hospital as a beneficiary.

The panel acknowledged that its decision created a split among the circuits. "We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes." 461 F.3d at 539 (App. at 18a). The panel opined that to the extent the other circuits relied for their preemption findings on ERISA's silence regarding assignability, their reasoning was incorrect. Further, the panel held that this Court's rejection, beginning in *Travelers*, of an "uncritical literalism" in interpreting ERISA, required the panel to look to whether the state law "frustrated the federal interest in uniformity," and whether the state law was in an area of traditional state regulation.

---

[4] "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw,* 463 U.S. at 96.

461 F.3d at 540 (App. at 19a). Considering these factors, the panel opined that the statute would have at most a minimal burden on plan administration, and a minimal impact on nationally uniform plan administration. 461 F.3d at 539 (App. at 18a).

Finally, considering the parties' opposing public policy arguments, the panel determined that nothing in ERISA required the court to alter the Louisiana legislature's decision to favor "assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks." *Id.*, at 541 (App. at 21a).

REASONS FOR GRANTING THE PETITION

I. INTRODUCTORY STATEMENT

In its determination that ERISA does not preempt the Assignment Statute, the Fifth Circuit has created an irreconcilable conflict not only with decisions of other circuits and this Court, but with express congressional intent. This case presents an ideal opportunity for this Court to provide much needed guidance and clarity regarding the scope of ERISA preemption, specifically with respect to the power of a state legislature to mandate a particular manner of paying ERISA plan benefits, while establishing a state law cause of action and remedy for an ERISA benefits claim.

In enacting ERISA, Congress adopted the broadest federal preemption clause ever written, "[reserving] to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local

regulation."[5] By preempting the field, Congress "meant to establish employee benefit plan regulation as exclusively a federal concern."[6] The express statutory terms reflect this intent.

ERISA Section 514(a), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they ... relate to any employee benefit plan." Pursuant to this provision, state laws are "expressly preempted" if they refer to or have a connection with ERISA plans.[7] This provision reflects congressional intent to preempt entirely the field of ERISA plan regulation as a matter of exclusive federal concern:

> The substantive and enforcement provisions of [ERISA] are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments ... which have the force or effect of law.[8]

However, as this Court has noted, the courts have struggled with the imprecise analysis that relies on the "relate to"

---

5 120 Cong. Rec. 29197 (1974) (statement of Representative Dent), cited in *Shaw*, 463 U.S. at 99.

6 *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

7 *Shaw*, 463 U.S. at 96.

8 120 Cong. Rec. 29933 (1974) (statement of Senator Williams), cited in *Shaw*, 463 U.S. at 99.

clause to identify the scope of the preempted field.[9] This case provides the Court with an ideal opportunity to clarify the meaning of "field preemption."

Section 502(a), 29 U.S.C. § 1132(a), provides the exclusive civil enforcement mechanism for claims to recover benefits or enforce ERISA plan rights. Claims for ERISA benefits necessarily arise under this provision – whether brought initially under state or federal law – and are impliedly or completely preempted; any such claim states an ERISA claim and is removable to federal court. *Davila*, 542 U.S. at 209. *See also Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987) (Congress clearly manifested intent to make causes of action within the scope of the civil enforcement provisions of §502(a) removable to federal court). Where state law provides an alternative enforcement mechanism outside this federal scheme, it "conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted." *Davila*, 542 U.S. at 209.

Notwithstanding Congress's clearly expressed intent, the explicit statutory provisions, and the 21 preemption

---

[9] *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring; Ginsburg, J., joining) (noting dissatisfaction with "relate to" analysis as a test for pre-emption, Justice Scalia states, "... [I]t accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption."); *Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring; Ginsburg, J., joining) ("[W]e can bring some coherence to this area...only by interpreting the 'relate to' clause as a reference to our ordinary pre-emption jurisprudence."); *Egelhoff*, 532 U.S. at 153 (Breyer, J., dissenting; Stevens, J., joining) (agreeing with Justice Scalia that court should apply normal conflict and field preemption principles rather than struggle to interpret the "relate to" clause).

decisions issued by this Court since ERISA's enactment,[10] the scope of ERISA preemption has remained a source of confusion. This case presents this Court with the opportunity to provide more definitive guidance to employers, employees, ERISA plans, plan participants, plan fiduciaries, plan sponsors, and reviewing courts.

For example, ERISA explicitly requires all governing plan documents to "specify the basis on which payments are made to and from the plan,"[11] thus placing the manner of benefits payment squarely within the plan sponsor's control. Despite this statutory directive and precisely analogous decisions to the contrary, the Fifth Circuit decision validates a state statute that ignores ERISA requirements and mandates the inclusion of crucial payment terms for all employee welfare benefit plans. Moreover, because the

---

[10] *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997); *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86 (1993); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corporation v. Holliday*, 498 U.S. 52 (1990); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

[11] ERISA Section 402(b)(4), 29 U.S.C. § 1102(b)(4).

panel determined that the Assignment Statute does not even satisfy the threshold "relate to" test for ERISA preemption, the decision arguably applies to all ERISA welfare plans, including self-funded as well as insured plans.[12]

The panel decision allows the state legislature to flout controlling, lawful ERISA plan terms and interfere with an ERISA plan sponsor's right to structure a benefits program in the manner it wishes, contravening the voluntary nature of ERISA welfare benefit plans. *See, e.g., Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (ERISA does not create any substantive entitlement to employer-provided health benefits; plan sponsors are generally free, for any reason at any time, to adopt, modify or terminate welfare plans). In addition, the panel decision conflicts directly with congressional intent that ERISA "enable employers 'to establish a uniform administrative scheme [and] a set of standard procedures to guide processing of claims and disbursement of benefits.' ... Uniformity is impossible... if plans are subject to different legal obligations in different states." *Egelhoff*, 532 U.S. at 148 (citation omitted). A state law that adds to the judicial remedies provided by ERISA "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards..." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002). Moreover, the panel decision ignores congressional intent to minimize cost burdens on plans through ensuring uniformity

---

[12] ERISA welfare benefit plans may either self-insure or purchase insurance from an insurance company to satisfy their obligations to participants. Those plans that do not purchase an insurance policy are called "self-funded" or "self-insured" plans; those that purchase insurance are called "insured" or "fully insured" plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

and predictability; *see, e.g., Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (courts should consider "competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, ... and, ... its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.")

Justices of this Court have bemoaned the fact that "our prior decisions have not succeeded in bringing clarity to the law."[13] Review of the panel's decision here – which muddies the ERISA preemption quagmire – provides an ideal occasion for this Court to provide that clarity, both with respect to express preemption of state laws that relate to the field of employee benefit plans, and implied preemption of state laws that conflict with ERISA's exclusive civil enforcement scheme.

II. ARGUMENT

A. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that relate to ERISA plan administration.

Under ERISA, the governing plan documents are paramount. Every plan must be established and maintained pursuant to a written instrument.[14] Plan administration obligations and duties are set forth in and derive from the

---

[13] *Dillingham*, 519 U.S. at 335 (Scalia, J., concurring; Ginsburg, J., joining); *Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring; Ginsburg, J., joining, *and* Breyer, J., dissenting; Stevens, J., joining). *See* footnote 9, *supra*.

[14] ERISA Section 402(a)(1), 29 U.S.C. § 1102(a)(1).

ERISA plan terms. ERISA requires that the governing plan documents include provisions that "specify the basis on which payments are made to and from the plan."[15] ERISA further requires a plan fiduciary to administer the plan "in accordance with the documents ... governing the plan," making payments to a "person designated by a participant, or by the terms of [a plan], who is or may become entitled to a benefit thereunder."[16] A plan participant or beneficiary may bring an action "to recover benefits due ... *under the terms of his plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*..."[17]

Consistent with ERISA directives regarding the supremacy of ERISA plan terms, state laws relate to ERISA, and must be preempted, if they purport to regulate the administration and structure of an ERISA plan, as reflected in those plan terms. ERISA's express preemption provision provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a)...." ERISA Section 514(a), 29 U.S.C. § 1144(a).

Although this Court's interpretation of this "relate to" clause has evolved in the 30 years since ERISA's enactment, one constant remains: State laws have an impermissible connection with ERISA plans, and are preempted by ERISA, if they regulate matters relating to plan administration, benefit payment, and ERISA obligations, "thus implicat[ing]

---

15 ERISA Section 402(b)(4), 29 U.S.C. §§ 1102(b)(4).

16 ERISA Sections 404(a)(1)(D) and 3(8), 29 U.S.C. §§1104(a)(1)(D) and 1002(8), respectively.

17 ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (emphasis added).

an area of core ERISA concern." *Egelhoff*, 532 U.S. at 147. *See also Travelers*, 514 U.S. at 658 (state law has impermissible connection with an ERISA plan if it mandates employee benefit structure or its administration); *Dillingham*, 519 U.S. at 333 (state law has impermissible connection with an ERISA plan if it is "tantamount to a compulsion" upon the plan).

The panel decision contravenes or overlooks authority from this Court regarding ERISA's preemptive power over state laws that compel plan structures or require administrators to pay benefits in a particular manner. This Court in *Egelhoff* held that ERISA preempted a state statute that revoked, upon divorce, a former spouse's designation as beneficiary under the terms of the plan. This Court held the state statute had an impermissible connection with, and thus related to, ERISA because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status. The administrators must pay benefits to the beneficiaries chosen by state law, *rather than to those identified in the plan documents*." 532 U.S. at 147 (emphasis added). The statute violated ERISA "because under this statute, the only way the fiduciary can administer the plan according to its terms is to change the very terms he is supposed to follow." 532 U.S. at 151 n.4.

The panel's efforts to distinguish *Egelhoff* are unconvincing. For example, in concluding that its decision is consistent with ERISA's definition of "beneficiary," the panel gives short shrift to the express statutory terms. ERISA Section 3(8) defines a beneficiary as "a person designated by a participant, or by the terms of an employee benefit plan, *who is or may become entitled to a benefit thereunder*." 29 U.S.C. § 1002(8) [emphasis added].[18]

---

[18] "...[A] 'beneficiary' is not anyone who claims to be one...[but] is one who has a reasonable or colorable claim to benefits.'" *Cobb v.*

Significantly omitted from the panel's analysis is consideration of the ERISA requirement that the designated beneficiary be *entitled to benefits under the terms of the plan.* This Court explicitly based its *Egelhoff* preemption ruling in part on the principle that an ERISA beneficiary, no matter how the designation is accomplished, must be a permissible beneficiary under the plan terms, holding the Washington statute preempted because it mandated benefit payments to beneficiaries chosen by state law *in contravention of valid plan terms:*

> The statute ... runs counter to ERISA's commands that a plan shall 'specify the basis on which payments are made to and from the plan,' § 1102(b)(4), and that the fiduciary shall administer the plan 'in accordance with the documents and instruments governing the plan,' § 1104(a)(1)(D), making payments to a 'beneficiary' who is 'designated by a participant, or by the terms of [the] plan.' § 1002(8).

532 U.S. at 147. Though it quoted selectively from *Egelhoff,* the panel failed to follow its overriding instruction to evaluate the validity of a state statute by considering its impact on the ERISA objectives of ensuring that plan administration, and benefit payment, occur in accordance with valid plan provisions, unencumbered by disparate state laws purporting to regulate matters relating to plan administration and benefit payment.

Cent. States, 461 F.3d 632, 635 n.3 (5th Cir. 2006) (citation omitted). *Egelhoff* confirms that if the plan prohibits payment of benefits to a non-participating provider, such a provider cannot be a valid beneficiary.

B. The Court should grant review because the Fifth Circuit decision conflicts directly with decisions of other circuits.

The panel acknowledged that its decision is in direct conflict with those of the Eighth and Tenth Circuits. "We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes." 461 F.3d at 539 (App. at 18a). The existence of this conflict supports the granting of Blue Cross's petition. *See* S. Ct. R. 10(a); *Braxton v. United States*, 500 U.S. 344, 347 (1991) ("A principal purpose for which we use our certiorari jurisdiction ... is to resolve conflicts among the United States courts of appeals ... concerning the meaning of provisions of federal law.").

In *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992), the Eighth Circuit determined that ERISA preempted an Arkansas statute requiring recognition of all assignments, including assignments of insurance benefits, because the statute negated the ERISA plan's non-assignment provision; shifted control over benefits payments from administrator to beneficiary, thus changing the plan structure and affecting the relationship between primary ERISA entities; had an intrastate and interstate impact on plan administration; and had an economic impact on ERISA plans resulting from elimination of an incentive for provider participation agreements. In *St. Francis Regional Medical Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460 (10th Cir. 1995), the Tenth Circuit held that an analogous state statute related to ERISA plans because its enforcement would directly impact ERISA plan provisions. The Tenth Circuit determined that allowing states to dictate the assignability of benefits would constitute an "improper interference" with ERISA plans and Congress's "laissez-faire attitude of

declining to establish any statutory rule" regarding assignability. 49 F.3d at 1464.[19]

As justification for creating this split of authority, the panel opined that the other circuits misinterpreted ERISA's silence regarding assignment of benefits, and that intervening Supreme Court authority rendered the conflicting decisions no longer valid. Blue Cross respectfully submits that both of these justifications are misguided and unsupported by the law.

In the panel's view, congressional silence regarding assignability is irrelevant to its determination of whether ERISA preempts the Assignment Statute; to the extent the Eighth and Tenth Circuits held otherwise, the panel asserts they were incorrect. The panel's conclusion conflicts with decisions in other circuits,[20] as well as decisions within the Fifth Circuit,[21] holding that assignability is a matter left to

---

[19] District courts within the Seventh Circuit also have held ERISA preempts state assignment or direct payment statutes; *see DeBartolo v. Blue Cross Blue Shield of Illinois*, No. 01 C 5940, 2001 WL 1403012 (N.D. Ill. Nov. 9, 2001); *Surgicore, Inc. v. Principal Life Ins. Co.*, No. 01 C 9387, 2002 WL 1052034 (N.D. Ill. May 22, 2002).

[20] *See, e.g., City of Hope Nat'l Med. Center v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) (ERISA leaves assignability or non-assignability of ERISA plan health benefits to negotiations of contracting parties); *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295 (11th Cir.) (ERISA-governed plans are contracts, and parties are free to bargain for certain provisions, including assignability; unambiguous anti-assignment provision in ERISA-governed welfare benefit plan is valid and enforceable), *cert. denied*, 543 U.S. 1002 (2004).

[21] *See, e.g., LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 353 (5th Cir. 2002) (ERISA plan's anti-assignment provision was valid and rendered nugatory any purported assignment).

the negotiation of the parties to the ERISA contract, an anti-assignment clause in an ERISA plan is lawful and enforceable, and an assignment is ineffectual if the ERISA plan contains an anti-assignment provision. These courts relied on the same principles that informed the determinations in the Eighth and Tenth Circuits that state anti-assignment statutes must be preempted; namely, that Congress's silence regarding assignments in welfare plans shows an intent "to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." *Davidowitz v. Delta Dental Plan, Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991).

The panel considered *St. Mary's* and *St. Francis* unpersuasive for the additional reason that they were decided before this Court's decision in *Travelers*. However, this Court in *Travelers* reaffirmed that ERISA preempts state laws that impact ERISA obligations, *i.e.*, because they (1) entitled employees to "benefits in excess of what plan administrators intended to provide," (2) "prevent[ed] plans from using a method of calculating benefits permitted by federal law," (3) "mandated employee benefit structures or their administration," or (4) provided "alternative enforcement mechanisms." 514 U.S. at 658. These factors, expressly still relevant under the less literal analysis endorsed by *Travelers*, are met by the Assignment Statute. The conflicting Eighth and Tenth Circuit decisions relied on these factors, and thus *Travelers* has no impact on their continued validity; *see St. Mary's* (concluding assignment statute "relates to" ERISA plan after considering factors such as negation of plan provision, effect on ERISA entities and plan structure, and impact on plan administration). *See also UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379 (1999) (state agency law that makes employer agent of insurer in performing plan administration duties relates to and is preempted by ERISA because it would have marked

effect on plan administration duties, including bookkeeping obligations regarding to whom benefit checks must be sent, and basic administrative services).

C. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that conflict with ERISA's exclusive enforcement mechanism.

As this Court has recognized frequently and consistently, Congress enacted ERISA to protect the interests of participants in benefit plans by establishing a uniform and comprehensive regulatory regime that provides appropriate remedies, sanctions, and access to the Federal courts. *Davila*, 542 U.S. at 208. ERISA's expansive preemption provisions are intended to ensure that this regulation is "exclusively a federal concern," *id.*, citing *Alessi.*[22] The panel decision undermines this comprehensive regulatory framework and the principles of uniformity on which it is based.

In furtherance of this congressional purpose, ERISA's integrated enforcement mechanism is intended to provide the exclusive means of enforcement and remediation. *Id.* "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Against this clear expression of policy, citing *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 143-145 (1990), this Court held in *Davila* that "any state-law cause of action that duplicates, supplements, or supplants the ERISA

---

[22] 451 U.S. at 523.

civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted," even if the state law would otherwise be saved from preemption as a law regulating insurance. *Id.*, at 542 U.S. at 209, 217.[23] *See also Rush Prudential,* 536 U.S. at 377 ("Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the 'reservation of the business of insurance to the States,' . . . [T]he state insurance regulation [loses] out if it allows plan participants 'to obtain remedies ... that Congress rejected in ERISA,' [citations omitted].").

Under *Davila,* the Assignment Statute should be preempted because it establishes expressly a state cause of action "to collect benefits," thereby supplementing or supplanting ERISA's benefit claim procedure, and provides an extra-contractual remedy – payment of benefits to a provider in accordance with state law and in conflict with ERISA's exclusive civil enforcement scheme.

The panel decision sanctions the following scenario: A plan participant seeks medical services from a hospital outside his ERISA plan's participating provider network. Upon admission to the hospital, the participant is required to sign a form that purports to assign his right to plan benefits

---

[23] In *Davila*, this Court also held that the "extraordinary pre-emptive power" of ERISA's civil enforcement provisions not only resulted in preemption of duplicative or supplementary state-law causes of action, but completely preempted such state law claims for ERISA benefits, converting them into federal law claims, removable to federal court. 542 U.S. at 209. Complete preemption, which addresses federal jurisdiction and removal, is not directly at issue in this lawsuit. Blue Cross submits, however, that if a hospital asserted a state law claim for benefits in state court, under *Davila*, it would be completely preempted and removable to federal court.

to the hospital. The hospital provides medical services and submits an invoice to Blue Cross, seeking payment of the plan benefits. However, following lawful ERISA plan provisions that prohibit assignments and permit direct payment of benefits only to plan participants or participating network providers, Blue Cross paid or will pay the plan benefits directly to the participant, rather than to the hospital.

The hospital then sues Blue Cross, seeking payment of those same benefits. Pursuant to ERISA and the lawful plan terms, the hospital is not a valid assignee, and therefore has no standing to assert an ERISA claim. Moreover, pursuant to ERISA and the lawful plan terms, Blue Cross has fulfilled its ERISA obligations in the only permissible way: by paying benefits directly to the participant.

Pursuant to the Louisiana Assignment Statute, however, the hospital may bring a state law cause of action against Blue Cross "to collect benefits," and Blue Cross is precluded from asserting as a defense the prior benefit payment to the participant. If the hospital prevails, state law compels Blue Cross to pay a sum of money to the hospital, representing a duplicate payment on the same obligation, or a penalty, either of which is an extra-contractual or punitive remedy not permitted under the terms of the plan or ERISA.[24]

The panel decision thus allows state law to trump not only lawful ERISA plan terms relating to plan administration and benefit payment obligations, but ERISA § 502(a)(1)(B),

---

[24] *See, e.g., Clancy v. Employers Health Ins. Co.*, 101 F. Supp. 2d 463, 467 (E.D. La. 2000) (ERISA preempts timely payment statute, LSA-R.S. 22:657, because by providing a penalty, it creates a "supplemental" state law remedy that conflicts with ERISA §502(a)'s exclusive remedy provision).

29 U.S.C. § 1132(a)(1)(B), the exclusive provision under which an action "to collect" ERISA benefits may be maintained. In addition, the panel decision violates the statutory directive of ERISA that ERISA plans must be administered in accordance with their lawful plan terms. *See Egelhoff*, 532 U.S. at 151 n. 4 ("[U]nder ... ERISA, a fiduciary 'shall' administer the plan 'in accordance with the documents ... governing the plan,' 29 U.S.C. § 1104(a)(1)(D). The [state] statute conflicts with this command because ... the only way the fiduciary can administer the plan according to its terms is to change the very terms he is supposed to follow.")

The panel rejected Blue Cross's argument that the statute contemplates a double payment of the same benefit. The panel reasoned that if Blue Cross complies with the Assignment Statute, it only pays the benefit once, and any "mistaken" payment to the participant could be remedied by seeking recovery of that payment from the person improperly paid. "Failure to follow the law cannot create preemption concerns." 461 F.3d at 536 (App. at 11a). What the panel ignores, however, are Blue Cross's obligation to follow federal law, which mandates benefit payment in accordance with plan terms, as well as the fact that those plan terms are lawful terms under ERISA. A payment to the plan participant will not be "mistaken"; rather, under ERISA, it is the only lawful result: a payment required by the plan and, thus, by the ERISA mandate to follow plan terms. The Assignment Statute purports to write this lawful term out of the plan, converting a term that is lawful under ERISA into one unlawful under state law. If the direct payment provision is in the plan, as ERISA permits, Blue Cross cannot comply with both state law and federal law. Thus, under the traditional "conflict preemption" analysis advocated by Justices of this Court in recent decisions, the

Assignment Statute must be preempted.[25] The panel held further that the Assignment Statute need not be preempted because "it does not impose any additional obligation on the ERISA plan administrator, nor does it create additional or separate means of enforcement," citing *Rush Prudential*, 536 U.S. at 379. The Assignment Statute clearly obliges the ERISA plan to pay benefits unauthorized under the plan terms, and provides the hospital-assignee with a separate means of enforcement under state law. The hospital is not a valid assignee under the plan, and therefore has no ERISA standing to assert a right to benefits; thus, the state law claim is in addition to or separate from an ERISA claim for benefits. An action under ERISA § 502(a) for benefits under one of Blue Cross's plans would have as an available remedy only the payment of benefits in the manner specified under the plan. The Assignment Statute "enlarges the claim" available under § 502(a) because it requires Blue Cross to pay money to the hospital even if it has already paid benefits to the participant, and even though the plan prohibits such payment, thereby creating an extra-contractual remedy that amounts to a penalty for following ERISA plan terms. Such extra-contractual relief is not available under ERISA. *See Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-147 (1985) (Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra-contractual damages caused by improper processing of benefit claims). The Assignment Statute thus is "incompatible with ERISA's enforcement scheme" because it "provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial

---

[25] Where compliance with both state law and ERISA is impossible, Congress intended that the state law must yield. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (preemption required 'where compliance with both federal and state regulations is a physical impossibility, ... or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'(citation omitted)).

remedies provided by ERISA," and "enlarge[s] the claim beyond the benefits available in any action brought under 1132(a)," *Rush Prudential,* 536 U.S. at 379-380.

D. This Court's review is warranted to resolve recurring questions of considerable significance to preemption jurisprudence, and of practical importance to the health care community.

Review by this Court is warranted not only to correct the panel's departure from precedents of this Court and of two other circuits, but to provide guidance on matters of public policy and federal preemption.

As a public policy matter, the issue presented here is of great significance to the parties impacted directly – employers who sponsor Blue Cross ERISA plans, plan participants, plan administrators, and health care providers both within and outside of the Blue Cross networks – as well as to the health care community generally. ERISA is structured to permit employers to choose whether to offer plans and to determine the plan's design. *See, e.g., Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (nothing in ERISA requires employers to establish employee benefits plans, nor does ERISA mandate what kind of benefits employers must provide). In making plan design decisions, employers seek to structure plans that are affordable both to the employer-sponsor and the employee-participant. This Court has recognized the "tension between the primary [ERISA] goal of benefiting employees and the subsidiary goal of containing pension costs." *Mertens v. Hewitt Associates*, 508 U.S. 248, 262 (1993) (citing *Alessi*, 451 U.S. at 515). Participating provider networks serve the public interest by keeping health care costs lower, and ERISA plans pass those savings on to plan participants. A plan provision that permits direct payment of benefits only to participating providers is

intended to induce providers to join the plan's participating provider network, thereby contributing to cost control. The Assignment Statute operates to eliminate this incentive and the resulting cost-savings, regardless of the plan sponsor's intended choice. The panel's decision represents a critical error and is so broadly worded that, arguably, it impacts all ERISA plans, included self-funded as well as insured plans. By sanctioning a state's direct regulation of ERISA plans, the panel decision will increase healthcare costs and discourage employers from establishing plans.

Respondents assert that the Assignment Statute serves the public interest by facilitating the delivery of medical treatment, 461 F.3d at 541 (App. at 20a), but it is not clear that ERISA plan participants, if given the choice, would choose the higher costs that would result from the diminution or elimination of the participating provider scheme. To the extent the Louisiana state legislature has "chosen assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks," as the panel suggests, *id.,* Blue Cross respectfully submits that this public policy choice is in error. In addition, a policy choice such as this one, that impacts the establishment of ERISA employee health benefit plans, should be made by Congress. *See Rush Prudential*, 536 U.S. at 402 (Thomas, J., dissenting) (while the advantages of allowing states to implement independent review requirements as a supplement to ERISA's exclusive enforcement scheme may outweigh any resultant disincentive to the formation of ERISA health benefit plans, this is a judgment that must be made by Congress).

Moreover, as a jurisprudential issue, this Court has recognized that the uncertainties of ERISA preemption have created an "avalanche of litigation"[26] both in this Court and

---

[26] *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 808 n.1 (1997).

in the lower courts.[27] The panel decision does little to restrain the avalanche; it creates a circuit split that flouts ERISA's framework and Congress's intent to ensure uniformity of enforcement. The Assignment Statute creates a new cause of action for ERISA benefits that "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential*, 536 U.S. at 379. This case presents an ideal vehicle for this Court not only to resolve the particular conflict among the circuits, but to revisit the purpose of ERISA preemption and craft an analytical scheme that would lend much-needed clarity to the law.

---

[27] The importance of ERISA preemption issues is underscored further by a simple Westlaw search for the time period of December 2005 through November 2006. A Westlaw search of United States District Court and United States Court of Appeals opinions deciding ERISA preemption issues demonstrates that approximately 500 opinions were issued on this topic in the preceding year.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

HOWARD SHAPIRO
Counsel of record
HEATHER G. MAGIER
PROSKAUER ROSE LLP
909 Poydras Street
Suite 1100
New Orleans, LA 70112
(504) 310-4088

Attorneys for Petitioner